STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	04/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure survey. Survey dates: April 15, 16, 17, 18, 19, 22, 23, and 24, 2013. Facility number: 000105 Provider number: 155198 AIM number: N/A Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Gloria Bond, R.N. (4/15, 16, 17, 18) Census bed type: SNF--75 Residential--55 Total--130 Census payor type: Medicare--22 Other--108 Total--130 Residential Sample: 7 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality Review completed by Tammy	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Alley RN on May 1, 2013.			

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F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to follow a residents' preference regarding her wake up and bed times for 1 of 3 residents reviewed for choices. (Resident #114) Findings include: In an interview on 4/15/13 at 3:10 P.M., Resident #114 indicated she did not get to choose when she wakes up and prefers not to be woke up before 7 A.M. There was no information noted in care plan regarding choices with bed time. The Physician's Recapitulation for March 2013 indicated, "Do not wake before 9 am -prefers to go to bed at 10 P.M....." There was a physician's order dated 4/11/13 to discontinue the do not	F000242	The creation and submission of this plan of correction does not constitute an admission of any conclusion set forth in the statement of deficiencies of any violations of regulations **F 242** **What corrective actions will be accomplished for those residents found to have been affected by this practice?** Marquette is the first healthcare facility in the State of Indiana to be accredited in Person-Centered Care by CARF-CCAC. Resident #113 is a wonderful person who is often inconsistent with her preferences for getting up and going to bed. Because of her diagnosis of expressive/receptive aphasia, she often has difficulty making her precise wishes known. It is possible for her answer to the surveyor's question about getting up and down to bed was meant to express the affirmative. She is in frequent contact with her two daughters and would share with them any issues	05/20/2013

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	wake before 9 A.M. and prefers to go to bed at 10 P.M. However, there was no documentation in the social service notes or the nursing notes regarding discussion with resident or physician to support this order. The physician had not signed the order. The Medication Administration Record during the month of March had medication pass times indicating medications given at 7 A.M., and 8 A.M., for 10 days out of the month. 3.1-3(u)(1)		she might have regarding her care at Marquette. Her daughters have indicated no such concerns. Resident has requested to attend breakfast in the dining room at 7:00 am. Resident wishes are as the current order states. Resident has displayed a desire to be up and in the dining room for breakfast, enjoying her hot chocolate as she visits with other residents. **How have other residents having the potential to be affected by the same practice been identified and what corrective action has been taken?** Resident preference is asked upon admission and indicated on the Resident Information Sheet which is given to staff on a daily basis. Updates to the RIS are completed during morning clinical meeting. Resident right of choice is reviewed at monthly Resident Council Meeting and during care plan conferences. **What measures will be put into place or what systemic changes will be made to ensure that this practice does not recur?** Importance of resident choice will be reviewed with staff during in-service training May 16 th -20 th . Community has joined with Advancing Excellence to participate in the Person Centered Care initiative. Marquette is also	

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			currently participating in the Health Care Excel Nursing Home Learning Collaborative. Resident preferences will be reviewed and updated during quarterly care plan conferences or as they share their wishes with their caregivers. **How will the corrective actions be monitored to ensure this practice does not recur?** Members of the Interdisciplinary Team will interview at least two residents twice weekly for one month, two residents weekly for one month and then two residents, and new residents quarterly thereafter. Residents will be interviewed with preferences/choices documented on their Resident Information sheet and care plan. Results of the interviews will be documented on the appropriate forms and submitted to the QAPI team for review and determination of need for PIP and additional monitoring. Attachment: Audit Form #1 **Compliance Date:** May 20, 2013	

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to follow the care plan for activities of daily living care for a resident who displayed behaviors for 1 of 26 residents reviewed for care plans. (Resident #208) Findings include: During an interview with Resident # 114 on 4/15/2013 3:15 p.m., yelling was heard from a resident on the other side of the wall in room # 201. During an observation of CNA #6 providing care to resident #208 residing in room #201on 4/15/13 at 3:16 p.m., Resident #208 was screaming during care telling the CNA to "stop" and "no." The CNA was moving the resident on her right side and repositioning her head under the right side of neck with a pillow. CNA #6 indicated the resident always yelled like this and was even worse after physical therapy. She indicated you can barely even touch her without her crying out. The CNA was moving	F000282	F 282**What corrective actions will be accomplished for those residents found to have been affected by this practice?** Resident # 208 was still new to community on 4/15/13, having admitted on 4/12/13. Assessments were still being conducted to learn resident's needs. Due to severe aphasia and inability to verbalize needs, the staff was learning how to best provide care, including sister in reviewing approach and best methods to use. Her sister indicated that resident experienced same reaction to care-giving while in the hospital. Nursing staff and Therapy report that resident is rarely experiencing negative response to care, currently. Resident has been able to become trustful of nursing and therapy staff and is improving daily. **How have other residents having the potential to be affected by the same practice been identified and what corrective action has been taken?** All residents with dysphasia have the potential to be affected by this practice. Review of RIS (Resident Information Sheet) and care plans will be completed on all	05/20/2013

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	quickly while doing care. In an interview with LPN #4 on 4/15/13 at 3:20 p.m., she indicated the resident yells during all care. The care plan for resident dated 4/12/13, indicated the resident had impaired cognition and decision making as related to dementia and intracranial hemorrhage of the occipital lobe. Interventions included, but were not limited to, " ...explain all care,...provide slow, calm interactions with her. Do not be rushed or moving quickly around her...." 3.1-35(g)(2)		residents with aphasia issues to ensure appropriate approaches are used during care. **What measures will be put into place or what systemic changes will be ;made to ensure that this practice does not recur?** All care giving staff in-serviced May 16 th – 20 th , to recognize resident need for slow, calm approach to care-giving, when cognition is compromised. Review of RIS (Resident Information Sheet) and its key components to be reviewed during in-service, same dates as above. **How will the corrective actions be monitored to ensure this practice does not recur?** Unit managers or other nurse managers will observe care of residents with aphasia or cognition issues. At least two residents will be observed during care twice weekly for one month, weekly for one month and then quarterly thereafter. Opportunities for teaching and training staff will be addressed during these observations. Audits will be documented of the observations with results of the audit submitted to the monthly QAPI team meeting for review and recommendations of PIP if warranted. Attachment: Audit form #2 **Compliance Date** : May 20, 2013	

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F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to	F000441	F441 **What corrective actions will be accomplished for those**	05/20/2013

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	ensure effective infection control procedures to prevent cross-contamination were implemented, related to contact isolation techniques, handwashing, disposable glove use, and positioning of a Foley catheter drainage bag. These deficient practices involved 1 LPN using gloves while administering medication (Resident # 10 and LPN # 4) and 2 CNA's who were providing care for 1 of 1 resident observed in contact isolation for a urinary tract infection. (Resident #146, CNA #7 and #8) Findings include: 1. On 4/17/13 at 3:16 P.M., Resident #146 was observed in his room, in a low bed with a mat beside the bed. A Foley catheter drainage bag, inside dignity cover, was observed laying flat on the floor, on the mat. On 4/19/13 at 12:57 P.M., the resident was observed sitting in a high-back wheelchair in the "Activities" lounge across from the Nurses Station. At 1:06 P.M., CNA #7 wheeled the resident to his room. She was observed to put on a disposable mask and gloves, but no disposable gown.		**residents found to have been affected by this practice?** Resident # 146 is currently off antibiotics after second negative urinary culture. He is no longer in isolation. Resident has catheter and has had recurrent infections, secondary to catheter placement, however resident is unable to empty bladder without the assistance of the catheter.Resident #10 has shown no signs or symptoms of eye infection. **How have other residents having the potential to be affected by the same practice been identified and what corrective action has been taken?** Those residents who have catheters or receive eye drops have a potential to be affected by this practice. All resident with Foley catheters will be assessed by 5/17/13 for signs and symptoms of UTI's and the physician will be notified accordingly. According to CASPER report for dates 2/1/13 – 4/40/13 our facility adjusted percentage is 2.1% as opposed to the state and national average percentage of 7.1%.All residents with physician ordered eye drops will be assessed by 5/17/13 for signs and symptoms of infection and physician will be notified accordingly. (Attachment # 9 & 10)**What measures will be put into place or what systemic changes will be ;made to ensure that this practice does**	

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	She had a front-zip hooded sweatshirt on over her uniform. She took the wheelchair pedals and foot cushion off the wheelchair and set them to the side. As she was doing this, she was touching and pulling at her sweatshirt sleeves and collar. The CNA took off the mask and gloves, and told the resident she needed to get another person to help put him in bed, and left room. The CNA did not wash her hands before leaving the room. At 1:10 P.M., CNA #7 came back to the room and told the resident she could not find anyone to help transfer him into bed. Without putting on gloves, she put the foot pedals on the wheelchair and pushed the resident out of the room and back to the Activity lounge. When she reached the Activity lounge, she found another CNA to assist in transferring the resident to bed. At 1:23 P.M. CNA #8 brought a Hoyer lift into the resident's room. She left the room to find a sling to use with the lift. CNA #7 put on a gown, a mask and gloves, and started to prepare the resident to use the stand up lift. CNA #8 put on a gown, gloves, and mask. During the transfer, both CNAs were		**not recur?** All nursing staff will be in-serviced on Isolation Precautions and Contact Precautions by 5/20/13. Hand washing and donning and doffing of PPE will also be in-serviced by 5/20/13. Eye drop administration will be included in the training. In-servicing will be conducted in lab setting to ensure understanding and compliance through competency checks. (Attachment #11)**How will the corrective actions be monitored to ensure this practice does not recur?** Unit managers and/or nurse managers will observe at least two residents receiving eye drops and two residents receiving isolation care twice weekly for one month. (If two residents are not in isolation, staff will be observed donning and doffing PPE in lab setting.) Then review will be done of two residents per week for a month and two residents quarterly thereafter. Results of the audits of these procedures will be submitted to the QAPI team for review and recommendations of PIP if necessary. (Attachment # 12/Audit form #4).**Compliance Date:** May 20, 2013	

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	touching the lift, the resident, the wheelchair, the catheter drainage bag (which was not in a dignity cover), the bed controls and linen. Both were repeatedly pulling up the cover gown to their shoulders to keep it from falling down because the gowns were tied only around the waist, and not at the neck. At one point, CNA #8 reached into her uniform pocket (under the cover gown) for her assignment sheet. After transferring the resident into bed, CNA #7 emptied the catheter drainage bag into a measuring container. CNA #8 commented to the ADON, who had entered the room, that she thought the catheter tubing was leaking--there were small spots of urine on the floor and the tubing was wet. The ADON looked at the drainage bag, and indicated she thought the clamp on the tube to empty the bag was not tight. She indicated she would come back a little later and check the tubing to be sure. In an interview at that time, the ADON indicated the resident was on "Contact" isolation due to urinary MRSA (Methicillin resistant Staphylococcus aureus). She said "The girls don't really need to be masked."			

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In an interview at that time, CNA #7 indicated she had received training on contact isolation procedures and techniques.

CNA #8 removed her gloves, mask, and gown and disposed of them in a plastic bag in the room. While she was washing her hands, CNA #8 indicated she had received inservicing on isolation procedures and techniques sometime at the end of last year. She then left the room.

At 1:45 P.M., CNA #7 took off her mask, gloves, and gown outside the resident's room, but came into the doorway to dispose of them in a plastic bag. She did not wash hands after taking the items off. The ADON reminded her to wash hands before she left, but then told her to take a container of sanitizing wipes to the nurse-- "They shouldn't be left out." CNA #7 picked up two plastic bags of the bagged linen and trash, as well as the large container of wipes, and walked down the hall toward the Nurse's Station, stopping once to open the door to the soiled linen closet. She did not wash her hands before exiting the room.

On 4/19/13 at 2:00 P.M., the resident

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	was observed to be in his bed, in a low position. The catheter drainage bag was laying on the floor beside his bed on the mat. The clinical record for Resident #146 was reviewed on 4/22/13 at 1:11 P.M. Diagnoses included, but were not limited to, advanced end-stage dementia--vascular type, acute renal failure secondary to bladder outflow obstruction, benign prostatic hypertrophy, aspiration pneumonia, diabetes, depression, bladder calculus, and urinary tract infection. The April 2013 physician order recap (recapitulation) sheet included an order, dated 1/24/13, for "Foley catheter; catheter care per CNA with AM and PM care; dignity bag while up in W/C (wheelchair)...." Other physician orders included: 2/4/13--Keflex (antibiotic) 500 mg. (milligrams) 1 by mouth twice a day for 3 days 3/20/13--Call urologist 4/6/13--Send urine for UA (urinalysis), C&S (culture and sensitivity) stat (immediately)--Fever, cloudy urine. 4/7/13--Levaquin (an antibiotic medication) 250 mg. 1 by mouth daily for 10 days--UTI (urinary tract			

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	infection) 4/9/13--D/C Levaquin. Start Bactrim (antibiotic) 80/400 mg. 1 tab by mouth twice a day for 10 days 4/10/13--Late entry for 4/9/13: Contact isolation precautions, Diagnosis: MRSA/Urine On 4/23/13 at 1:25 P.M., the Director of Nursing provided the policy and procedures for isolation precautions. The "Policy for Isolation Precautions" was not dated, but indicated "... The 2007 Centers for Disease Control and Prevention (CDC) Guidelines for Isolation Precautions will be utilized in this facility with some modifications...." The policy portion of the paper indicated "... Standard Precautions combine the major features of Universal Precautions and Body Substance Isolation and are based on the principle that all blood, body fluids, secretions, excretions (except sweat), nonintact skin, and mucous membranes may contain transmissible infectious agents. Standard precautions consist of a group of infection prevention practices that apply to all residents... These include hand hygiene; use of glove, gown, mask, eye protection, or face shield, depending on the anticipated exposure...."			

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	The "Procedure for Isolation: Initiation of Isolation Precautions" portion included, but was not limited to, the following: "...3. Contact Precautions: In addition to Standard Precautions, use Contact Precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident-care items.... The above includes epidemiologically important organisms (multidrug-resistant organisms) such as methicillin-resistant Staphylococcus aureus (MRSA)... IV. Gather equipment;... D. Obtain thermometer or any other equipment that is to be dedicated to that resident's care... **Points to Remember**: Handwashing (hand hygiene) is the single most important precaution to prevent the transmission of infection from one person to another. Wash hands with soap and water before and after each resident contact, and after contact with resident belongings and equipment...			

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	155198	A. BUILDING 00 B. WING	04/24/2013

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	All personal protective equipment (disposable isolation gowns, mask, gloves, etc.) should be used once and discarded in either the trash or used linen receptacle before you leave the room... **Contact Precautions**: Wear clean gloves when entering the resident's room or unit if a multibed room. Wear a gown when entering resident area if you anticipate that you will have substantial contact with the resident, resident items, or environmental surfaces of if the resident is incontinent. Remove gown carefully before leaving the room and wash hands. During care, change gloves after having contact with infective material... Remove gloves before leaving resident area. Wash hands immediately with soap and water... Limit resident movement and transport... When possible, dedicate equipment to a single resident...			

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	DONNING PPE (Personal Protective Equipment) Gown: Fully cover torso from neck to knees... Fasten in back at neck and waist **SAFE WORK PRACTICES** Keep hands away from face; work from dirty to clean; limit surfaces touched; perform hand hygiene...." 2. ON 4/23/13 at 9:30 a.m., while observing LPN # 4 during medication pass for Resident #10, she did not wash or sanitize her hands before placing gloves on her hands and preparing medications. LPN #4 gave the resident her medications and then sanitized her hands. LPN #4 placed gloves on her hands, then touched the cart to shut the drawer to the cart, flipped the pages for the MAR (Medication Administration Record), and shut the MAR with her gloved hands. LPN #10 then administered eye drops to Resident #10. In an interview with the ADON on 4/23/13 at 9:35 a.m., she indicated staff should not touch items after putting gloves on and then give eye drops to a resident.			

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	3.1-18(b)(1)			

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F000520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview and record review, the facility failed to identify and address current and repeat non-compliance related to infection control procedures and techniques through the quality assurance protocol. This deficit practice had the potential to affect 75 of 75 resident's residing in the facility. Findings include:	F000520	F 520 **What corrective actions will be accomplished for those residents found to have been affected by this practice?** No resident was noted to be affected by this practice. Review of QA minutes for the past 3 years indicate that community was at or below state and national percentages for Infection QI/QM, no action plan deemed necessary. **How have other residents having the potential to be affected by the same practice been identified and**	05/20/2013

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	The pre-survey review of the CASPER (Certification and Survey Provider Enhanced Reporting System) report, related to past Federal regulation citations, indicated the facility had been cited in 2008, 2010, and 2012 for non-compliance with Infection Control issues. During the Recertification Survey process from 4/15/13 to 4/24/13, observations and interviews indicated isolation procedures and techniques were not followed for Resident #146 who was in Contact Isolation for a urinary tract infection. In addition, handwashing and disposable glove use procedures were not followed by a LPN during a medication pass observation. In an interview during the entrance conference on 4/15/13 at 10:00 A.M., the Administrator indicated the facility's QA (Quality Assurance) committee met quarterly as required. It was her intention, however, to have that changed to a monthly meeting. She had been in her position since the beginning of January, 2013 and had not yet been able to accomplish that goal. In an interview on 4/23/13 at 2:46 P.M., the Director of Nursing		**what corrective action has been taken?** All residents have the potential to be affected by this practice. **What measures will be put into place or what systemic changes will be ;made to ensure that this practice does not recur?** Administrator will incorporate the CASPER report into the QAPI team meeting monthly, as well as review of the community QI/QMs. Monthly QAPI meeting held on May 17, 2013 with meetings scheduled on the third Friday of each month going forward. (Attachment #13) **How will the corrective actions be monitored to ensure this practice does not recur?** QAPI team will identify those areas that require PIP on monthly basis and move forward accordingly. PIPs will be reviewed monthly with necessary updates until QAPI team deems area of concern to no longer warrant monthly review, based upon data collected. **Compliance Date:** May 20, 2013 Attachment: In-service records for F 241, F282, F 327, F 441	

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	indicated she only knew about 2012 citation for infection control. She started doing inservices on some aspects of infection control based on her own observations. The Director of Nursing indicated she did not take the issues to the QA committee because she first got promoted, then got sick and was out for 2 months. The Administrator indicated the QA Committee meetings were only occurring quarterly, and the the first one she attended was 4 days after she started (in January, 2013). The Administrator indicated she was not aware of previous infection control citations. 3.1-52(b)(2)			
R000000	The following Residential findings were cited in accordance with 410 IAC 16.2-5.	R000000		

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R000214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure a resident was evaluated after having falls for 1 of 5 residents reviewed for evaluations. (Resident # 276) Findings include: The record review for Resident # 276 was completed on 4/24/13 at 9:50 a.m. Diagnoses included, but were not limited to, high blood pressure, depression, urinary incontinence, history of urinary tract infection, depression and chronic obstructive pulmonary disease. The resident had notes in the record that indicated she had seen physical therapy from 6/19/12 through 7/27/12 to improve her gait, strength, and balance to assist in decreasing her risk for falls. The therapy notes indicated the resident discharged herself and did not want to continue	R000214	_The creation and submission of this plan of correction does not constitute an admission of any conclusion set forth in the statement of deficiencies of any violations of regulations.ResidentialR 214**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**Marquette maintains that resident # 276 did not sustain a significant change, therefore evaluation was not required, nor a change in service plan. (By 410.IAC. 16.2-1.1-70; “Significant Change” Sec. 70 “Significant Change means a major improvement or decline in residents physical, mental or psychosocial status.”) (Sec. 69 “Service Plan means a written plan for services to be provided by the facility developed by the facility, the resident and others, if appropriate, on behalf of the resident, consistent with the services needed to ensure the health and welfare of the resident.) Resident had one occurrence of fall and then two	05/20/2013

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	to get therapy due to pain and could not tolerate the exercises. The nurses' notes indicated the resident had a fall on 2/14/13, "...at approx [approximately] 5:15 a.m. res. [resident] activated mercy light. Found res lying on her back on the living room floor. Res stated she hit her head on one of her tables, but denied pain at that time. Res. does have some swelling [sign for at] the upper middle region of the occipital bone bone...." An incident report dated 4/10/13 indicated the resident reported she was sitting on the edge of her wheelchair and was going to transfer and slid out of her wheel chair. The service plan dated 3/22/13 indicated, "... Mobility, Monitor use of assistive device w/c (wheelchair) walker and encourage safety precautions. Transfer, no services needed at this time...." There was no information in the service plan to indicate the resident's risk or history of falls. In an interview with the Assisted Living Director on 4/22/13 at 12:50 p.m., she indicated she had no information regarding evalutaion after		months later slipped from a chair. No injury either time. Had resident been interviewed by survey team, this determination could have been made. **How are other residents having the potential to be affected by this practice identified and how will corrective action occur?** All residents may be affected by this practice. When resident displays a significant change, nursing will evaluate the change, performing an assessment and documenting result s in the nurses notes. With involvement from resident, physician and family, appropriate action will be recommended and followed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Nursing staff will communicate with Assisted Living Director all falls or significant changes through daily report or verbal or written message. Resident record will indicate documentation of follow up. Through review with the resident,(and/or family when appropriate) it will be determined if service plan changes are required and what outcome the resident desires. Nursing staff will be in-serviced on May 14 , 2013, regarding documentation and follow - up. Director of Assisted Living will review one resident chart for documentation weekly for a month and then quarterly thereafter. Attachment	

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	the falls, notification of the physician or how the facility was addressing the resident's falls.		#1 **How will the corrective actions be monitored to ensure the deficient practice will not recur.** Director of Assisted Living will review results of her audit with the administrator monthly for recommendations and follow through. Director of Assisted Living and Administrator will determine at what time audits may be changed.**Compliance Date:** May 20, 2013	

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R000217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure service plans were accurate for the care needed for 2 of 7 resident's reviewed for service plans. (Resident # 276 and # 259) Findings include:	R000217	R217**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**Resident #276 is doing well with transfers at this time, denies falls, since 4/10/13. Surveyor was unable to interview this resident as she was out of community attending event.	05/20/2013

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	1. The record review for Resident # 276 was completed on 4/24/13 at 9:50 a.m. Diagnoses included, but were not limited to, high blood pressure, depression, urinary incontinence, history of urinary tract infection, depression and chronic obstructive pulmonary disease. The resident had notes in the record that indicated she had seen physical therapy from 6/19/12 through 7/27/12 to improve her gait, strength, and balance to assist in decreasing her risk for falls. The therapy notes indicated the resident discharged herself and did not want to continue to get therapy due to pain and could not tolerate the exercises. The nurses' notes indicated the resident had a fall on 2/14/13, "...at approx [approximately] 5:15 a.m. res. [resident] activated mercy light. Found res lying on her back on the living room floor. Res stated she hit her head on one of her tables, but denied pain at that time. Res. does have some swelling [sign for at] the upper middle region of the occipital bone bone...."		Resident #259 continues to have some anxiety but is being seen routinely by Psych services. Resident #259 experienced a very difficult grieving period after her significant other passed away last fall. Currently resident is becoming more social, eating in dining room and participating in activities, fewer episodes of anxiety have been noted, service plan notes improvements. **How are other residents having the potential to be affected by this practice identified and how will corrective action occur?** All resident have the potential to be affected by this practice. All service plans will be reviewed by the Director of Assisted Living or nurse to ensure current accuracy and completeness.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Nursing staff will communicate with Assisted Living Director all falls or significant changes through daily report or through the 24 hour shift to shift report. Utilizing the information obtained through 24 hour shift to shift report and nurses' assessment, service plans will be changed or updated semiannually or when there is a significant change. Significant changes will be determined by the resident, staff, family and physician. Documentation of the review will be placed in the nurse's notes	

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	An incident report dated 4/10/13 indicated the resident reported she was sitting on the edge of her wheelchair and was going to transfer and slid out of the wheel chair. The service plan dated 3/22/13 indicated, "... Mobility, Monitor use of assistive device w/c (wheelchair) walker and encourage safety precautions. Transfer, no services needed at this time...." There was no documentation to indicate the resident's risk or history of falls and what if any assistance was needed to prevent falls. In an interview with the Assisted Living Director on 4/22/13 at 12:50 p.m., she indicated she there was no fall information on the service plan. 2. The record review for Resident #259 was completed on 4/24/13 at 12:45 p.m. Diagnoses included, but were not limited to, dementia, depression, anxiety, and arthritis. The nursing notes for Resident #259 indicated, "...10/14/12 12:20 p.m. Received call from security stating resident at apartment 1210 et [and] refusing to leave, kicking door et		with determination to move forward with service plan changes or not. Nursing staff will be in-serviced on May 14 , 2013, regarding documentation and follow - up. Director of Assisted Living or nurse will review one resident chart for documentation and potential need for service plan review, weekly for four weeks and then monthly until determined that audit no longer required. Residential Attachment #2 **How will the corrective actions be monitored to ensure the deficient practice will not recur.** Director of Assisted Living will review results of her audit with the administrator monthly for recommendations and follow through. Director of Assisted Living and Administrator will determine at what time audits may be changed.**Compliance Date:** May 20, 2013	

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	banging on it [sign for with] fist...11/29/12 resident + [positive] for [sign for increased] anxiety and restlessness [sign for secondary] to close friend being hospitalized...." The social service notes indicated 12/4/12, "...staff is to redirect when resident bring up [name of resident] and that if she continues to about him they will leave...1/16/13 resident very upset and confused today...asked SS [Social Services] if [name of male] was still alive...2/13/13 SS met [sign for with] resident on 2/12/13 in her apt. [apartment] Staff had reported that she had been crying...family continuing to work on setting up a personal companion for resident...2/22/13..Family phone and informed of situation, Family shared past hx [history] of paranoia that resident displayed upon moving to Marquette [sign for with] regards to a boyfriend. Caregiver came to facility and met with resident...2/25/13 Reports were made to nursing staff that over the weekend resident repeatedly called private duty caregiver wanting him to come over. Staff feel that resident is viewing caregiver as a 'boyfriend' and is unable to make a distinction. POA and staff both agree to discontinue private duty services...Family has			

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	noted [up arrow] paranoia and said even with female private duty's that she had in the past she developed paranoia [delusion] around and about them...2/28/13 Staff received a report that resident had been to facility's reflections unit 3 x today looking for 'that gentleman' sometimes she calls him '[name of male]' sometimes she calls him '[name of male].' 3/13/13 PCP [primary care physician] wrote an order for the resident to be admitted to the psych [psychiatric] unit/and/or receive 24 hr. [hour] companion service...son stated at this time he did not want his mother sent out to the psych unit...3/18/13...she continues to walk around facility 'looking for someone'...4/10/13...she does still 'look for' her deceased male friend around the facility but is easily redirected...." The service plan for Resident # 276 dated 4/4/13, in the behaviors section indicated, "keep family informed of residents behaviors" and for mental status indicated, "provide an opportunity for resident to share feelings and provide reality orientation as needed...." There was no information regarding the resident's behaviors of crying or looking for her male friend and what staff are to do if this behavior occurs.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000297	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure that 1 resident received all doses of a medication ordered by his physician by obtaining that medication from the facility's contracted pharmacy when the resident's family did not provide it from their chosen pharmacy for 1 of 1 resident reviewed in a sample of 7 residents. (Resident #350) Findings include: The closed clinical record for Resident #350 was reviewed on 4/24/13 at 12:30 P.M. The resident was admitted to the facility on 1/3/13 and expired on 1/9/13. Diagnoses included, but were not limited to, congestive heart failure, chronic kidney disease, hypertension, dementia, chronic obstructive pulmonary disease, and pleural effusion. An admission History and Physical, dated 12/27/12, indicated the resident	R000297	R 297**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #350 is no longer in community.**How are other residents having the potential to be affected by this practice identified and how will corrective action occur?** All resident have the potential to be affected by this practice. Audit of every MAR will be conducted to ensure that medications are available for each medication ordered, by 5/20/2013. Delivery of medications that have not arrive timely will be reported to Director of Assisted living or nurse and placed on 24 hour report for follow. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All Assisted Living Med Pass staff will be in-serviced on the requirement to obtain medication to be given timely as indicated in the physician orders. In-service will also include the	05/20/2013

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	had been prescribed the medication Advair (an inhalation medication for the lungs) 250/50 one puff twice a day. Upon admission to the facility, this medication was continued as well as an order for Spiriva (also a medication for the lungs). The January 2013 MAR (Medication Administration Record) listed the order for the Advair. All 12 doses between 1/3 and 1/9/13 were circled, indicating the medication had not been given. On the reverse side of the MAR, the "Nurse's Medication Notes" indicated the Advair medication was "on order from pharmacy," "continues to be on order from pharmacy," and "nurses are aware." In an interview on 4/23/13 at 3:15 P.M., the Administrator indicated she believed the family was providing the resident's medications from their own pharmacy. She was not sure if the facility had a policy/procedure for obtaining medications from the facility contracted pharmacy if the medications were not provided by the resident, family, or responsible party. In an interview on 4/24/13 at 4:10		need to complete medication error report and submit to Director of Assisted Living if medication not delivered timely. In-service will be conducted on May 14, 2013. If medication cannot be obtained, physician will be notified for further direction, with documentation of this in the resident record. Nurses will be expected to review MARs daily for medications not being given and notify the Director of Assisted Living immediately. Residents and families will be notified in admission documentation that if medication cannot be obtained from their pharmacy of choice, facility pharmacy will be contacted for initial dosage.Residential Attachment #2.**How will the corrective actions be monitored to ensure the deficient practice will not recur.** Director of Assisted Living will review 3 MARs weekly for four weeks then 3 MARs monthly thereafter to determine that no MAR indicates medication is not being given because of lack of availability. All Medication Error reports will be reviewed by Director of Assisted Living or nurse next business day to detect potential system failure. Director of Assisted Living or nurse will review the delivery slips from pharmacies to determine if medications not received from attending pharmacy have been ordered from community pharmacy. Results of these	

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	P.M., the Administrator indicated the resident's family was obtaining his medications from another local pharmacy, and that the Assisted Living Director of Nursing had not been aware the resident had not received the Advair. She provided an undated, three-page instruction sheet, titled "Assisted Living Pavilion--Important Move-In Procedures for New Residents." The section titled "Medications" included, but was not limited to, the following information: "... For residents currently using a mail-order pharmacy, we ask that you set up an account with one of the local 24-hour pharmacies [listed on next page] or [name of facility pharmacy], our contracted pharmacy. If you choose to continue with a mail order pharmacy other than [name of pharmacy], you would be responsible for re-ordering and have the medications delivered to the Pavilion nurses' station... If the mail order does not arrive in time for your move-in day, we will need to order a small supply through [name of pharmacy]...." In an interview on 4/24/13 at 4:20 P.M., the Assistant Living Director of Nursing indicated she had not been told that the Advair medication was		audits will be reviewed with the administrator monthly to ensure compliance. **Compliance Date:** May 20,2013	

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	still on order. She then indicated the resident's family did not want him to continue on the Advair "because it didn't work," and were not going to have the prescription filled. She indicated she did not have any documentation of this information, or of any conversation with the family about the medication. She also indicated she did not have any documentation about any attempts by nursing staff to obtain the medication from the contracted pharmacy.			

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R000349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to have complete documentation for 1 of 7 residents reviewed for documentation. (Resident # 276) Findings include: The record review for Resident # 276 was completed on 4/24/13 at 9:50 a.m. Diagnoses included, but were not limited to, high blood pressure, depression, urinary incontinence, history of urinary tract infection, depression and chronic obstructive pulmonary disease. The nurses notes for 10/16/12 indicated, "...Res [resident] stated that there was a man trying to get into her apt....a tall man trying to get in through her window. She also stated he had a woman [sign for with] him, and she didn't know how they got up to her 3rd floor window..."	R000349	R 349**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident informed nurse that television reflection in balcony door was what she saw. Resident verbalized same statement to social services with follow up on 4/26/13. Nurse who failed to document update, did receive education regarding need for completeness of follow through on any unusual reportings by residents. **How are other residents having the potential to be affected by this practice identified and how will corrective action occur?** All residents have the potential to be affected by this practice. Review of daily shift report sheet, from 4/24/2013 to current, will be completed to ensure no other resident has reported unusual occurrence that would require follow up.**What measures will be put into place or what systemic changes will be made to**	05/20/2013

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	In an interview with the Assisted Living Director (ALD) on 4/24/13 at 1:40 p.m., she indicated LPN #9 informed the ALD the resident later reported to LPN #9 she realized what she saw was a reflection from the television on her window. LPN #9 indicated she forgot to document it in nurses notes.		**ensure that the deficient practice does not recur?** Assisted Living Nursing staff will be in-serviced on May 14, 2013 to document in resident record and report on shift report any occurrence that would be deemed unusual for follow up documentation by next shift as well as social services. Residential Attachments # 1& 2. **How will the corrective actions be monitored to ensure the deficient practice will not recur.** Director of Assisted Living or nurse will review daily 24 hour shift report sheet for unusual occurrences and will audit documentation. Audits will be reviewed with the Administrator monthly to ensure compliance.**Compliance Date:** May 20, 2013	